Scheduling Process Implementation and Open Access Briefing

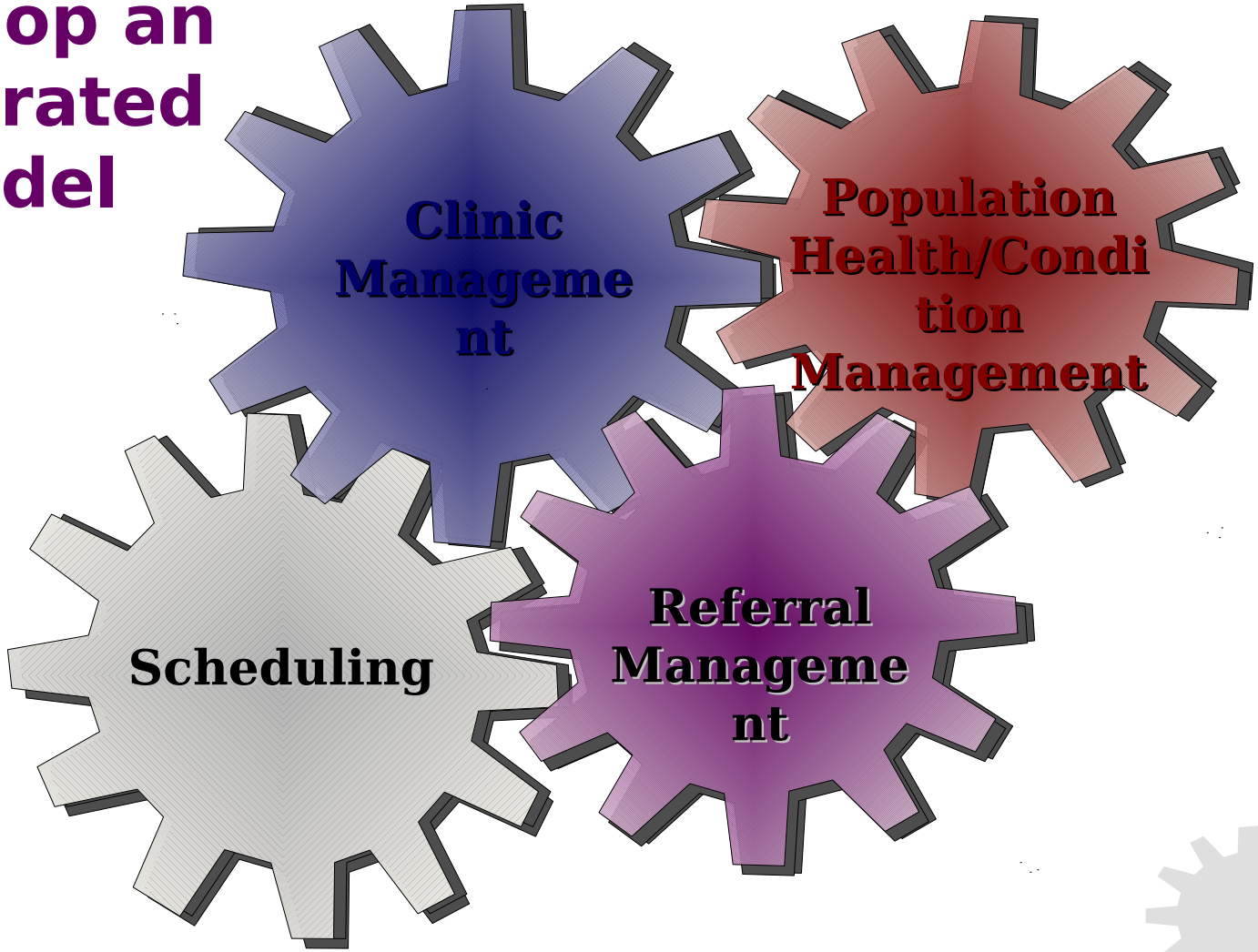
Block 5

APS Business Rules Training Seminar

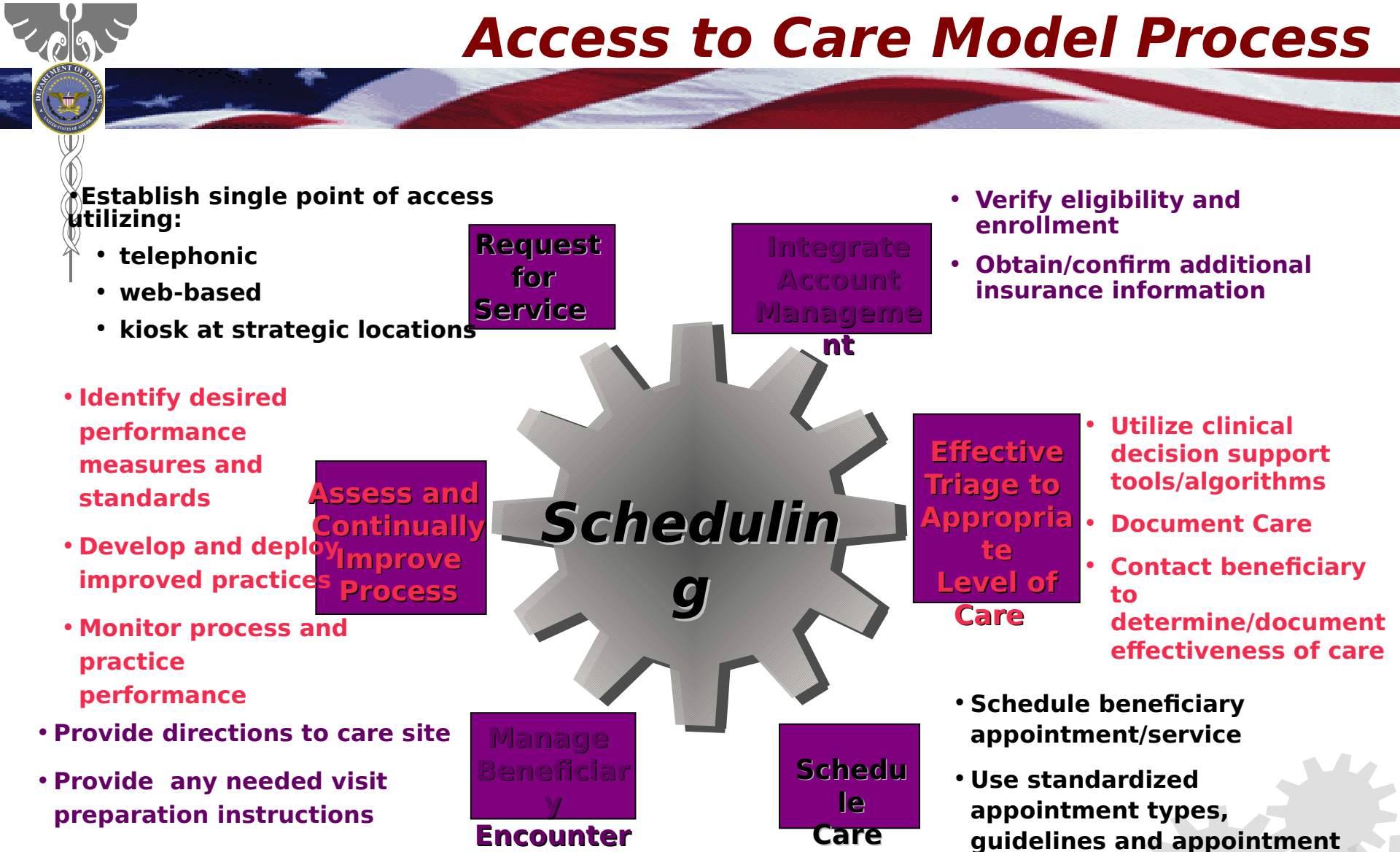
April and May, 2001

Objective

Develop an Integrated Model



Access to Care Model Process



- Establish single point of access utilizing:
  - telephonic
  - web-based
  - kiosk at strategic locations

- Verify eligibility and enrollment
- Obtain/confirm additional insurance information

- Identify desired performance measures and standards
- Develop and deploy improved practices
- Monitor process and practice performance

- Utilize clinical decision support tools/algorithms
- Document Care
- Contact beneficiary to determine/document effectiveness of care

- Provide directions to care site
- Provide any needed visit preparation instructions
- Arrange any Primary Care follow-up care at clinic discharge

- Schedule beneficiary appointment/service
- Use standardized appointment types, guidelines and appointment length
- Establish, maintain and adjust provider schedule templates

Approach

- Change from Beneficiary Appointing to Provider Scheduling – Redefine the process
- Assess current technology and upgrade as needed
- Pilot the model in 4 MTFs in Region One and 4 MTFs in Region Two
- Review pilot site results, enhance implementation template and rollout to remaining MTFs in Region One and Two

Current State Assessment

- *Making Appointments* and *Access to Care* - lowest rating in the Beneficiary Satisfaction Survey
- Long waits for specialty appointments
- Appointing process is confusing, time consuming and frustrating
  - Multiple telephone numbers
  - Complex menu options
  - Lengthy hold times & calls
- MTFs are absorbing appointing functions without budgeted staff
  - Reduction in patient care resources

Some Root Causes

- ***Lack of Trust*** in Managed Care Support Contractor
- Complex and non-standard appointment templates
- Lack appropriate appointment availability
- Lack of appropriate triage
- Lack of responsiveness to necessary unique scheduling requirements
- Insufficient provider availability
- Episodic problem management

Some Root Causes, continued

- High variability with MTF & clinic-specific appointing processes
- Lack of infrastructure and staffing resources at the MTFs/Clinics
  - Local clinic telephone access inconsistent
  - Inadequate telephone systems
  - Inadequate staffing in MTFs/Clinics
  - Clinic front desk processes/workflows outdated
- Lack of training in CHCS
- Poorly aligned metrics

Recommendations Summary

- Appointment scheduling responsibility is a shared process between the MTF and TSC staffs.
- Migrate scheduling functions to MTF aligned TRICARE Service Centers.
- Simplify access for primary care appointing.
- Improve application of scheduling best practices.
  - Redesign the workflows at the clinic front desk.
- Initiate follow-up scheduling from the PCM Office.
  - Initial specialty care appointment scheduling done at time of referral.

Future State Scheduling Flow

Beneficiary Dial Phone # or connect via the Web for appointment

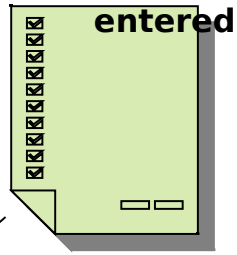
TRICARE Service Center

If no SDA available, call transferred to PCM clinic for triage and booking if necessary

PCM Office Visit

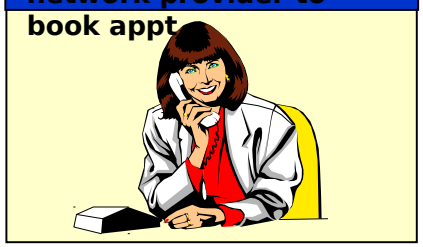
Follow-up appointments scheduled before leaving clinic

If SC needed Cln Order entered



Scheduling Clerk (TSC/MTF Location)

Uses CHCS to book MTF SC appt. or calls network provider to book appt



Yes

MTF SC Facility

No

Network SC Facility

If needed

Health Care Coordinator

Performs Review & authorization

Scheduling Staffing Model

1. The MTF based TSCs will be expanded to handle the Scheduling functions outlined in this model.

In summary each TSC will provide the following Beneficiary Services:

- Walk-up customer service for Appointment Scheduling, Claims, Enrollment, Referral Assistance and Patient Education.
  - This assistance will be provided by the CSR staff.
- Telephone requests for Appointment Scheduling.
  - This assistance will be provided by the scheduling clerks.

2. The MTF Clinic Staff will handle the Scheduling functions outlined in this model.

In summary each Clinic will provide the following Scheduling Services:

- Walk-up requests for Same Day Appointments and the scheduling of follow-up appointments as the patient leaves the clinic

Intersection in the Road – Which Way to Turn?

Implement Carve Out Access Model

Implement Advanced Access Model

Tweak Traditional Model

History of Open Access

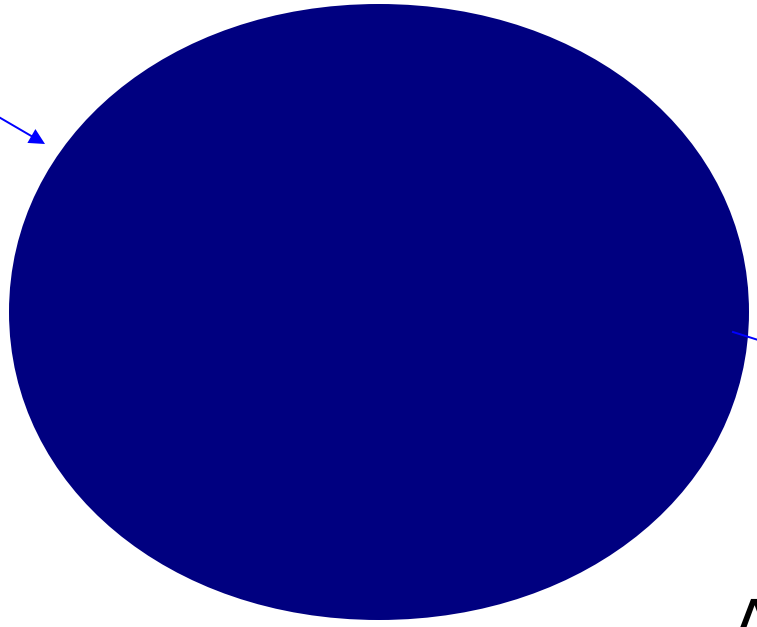
- Originated at Kaiser Permanente in CA
- Designed by Dr. Mark Murray and Catherine Tantau in early 1990's
- Original site serviced 100 providers with 300 support staff and 250,000 patients
- Reasons for Open Access:
  - Number one reason for patients leaving was access
  - "Tweaking" scheduling and upgrading telephony did not solve access issues
  - System was broken – patients saw PCM less than 50% of the time
- Situation after Open Access implementation:
  - Highest patient satisfaction
  - 80% of patient appointments were with PCM
  - Physicians felt they had control of their practice

Selected Open Access Sites

- Harvard Pilgrim (MS)
- Tanawanda Medical Associates (NY)
- Family Doctors (WI)
- Mayo Health Systems (WI)
- Alaska Native Health System (AL)
- Health Partners (IN)

The System of Supply and Demand

Reservoir Fills with Beneficiary Requests for Health Services



Reservoir Drains As Health Services Are Provided

The Delay Reservoir

Source: Murray and Tantau

How Do We Shrink the Size of the Reservoir?

- Move from Traditional Model
- Migrate to Carve Out Model or Advanced Access Model

Access Design Elements

- Continuity (appointment is with PCM). Each provider must be available for patient care 60% of the time.

- Appointment capacity (to meet beneficiary demand). There must be an adequate number of providers and support staff to provide health services.

Traditional Model

- Saturated Schedules
- Prove you are sick enough to be seen
- Attempt to manage demand with multiple appointment types, lengths and guidelines
- Capacity: "Overbook" and "Over There"
- Continuity: Available if you don't mind waiting, or if you get lucky

DO LAST MONTH'S WORK TODAY

Carve Out Model

- Reserve or Carve Out space in schedule for “urgent” care needs
- Predict demand for urgent care needs
- Continuity: May be met for urgent care
- Capacity: Future appointments filled or reserved

DO PART OF TODAY’S WORK TODAY

Carve Out Model – One Week View

	M	T	W	TH	F
50%	Routine Future X	Routine Future X	Routine Future X	Routine Future X	Routine Future X
50%	Open for Urgent	Held for Urgent	Held for Urgent	Held for Urgent	Held for Urgent

Source: Murray and Tantau

Advanced Access Model

- No distinction between urgent and routine
- Shift from episodic care to total continuity of care
- Backlog is eliminated (drain the reservoir)
- Continuity: The driving force is PCM/team availability
- Capacity: Future is open

DO ALL OF TODAY'S WORK TODAY

Advanced Access – One Week View

M	T	W	TH	F
F/U	F/U	F/U	F/U	F/U
Beneficiary Choice	Beneficiary Choice	Beneficiary Choice	Beneficiary Choice	Beneficiary Choice
OPEN	OPEN	OPEN	OPEN	OPEN

25%

75%

Source: Murray and Tantau

Carve Out – Advanced Access Comparison Summary

ACTION	CARVE OUT MODEL	ADVANCED ACCESS MODEL
CONTINUITY	Predict Urgent Care Demand	Appoint with PCM
CAPACITY	Reserve for urgent care	Future is open No distinction between urgent or routine
SCHEDULE VIEW	50% - 50% 50% appt's for same day 50% appt's for routine, future	75% - 25% 75% appt's for same day 12% appt's for F/U 13% appt's for beneficiary choice

What About "Triage"?

- Definition: Triage is a front-end demand management tool where every request for same-day service is screened for medical necessity and appropriateness
- Goal is to keep patients out of the office or guide them to other care sites or sources
- Patient must prove they are sick enough to be seen
- Resource intensive – nursing staff, computer algorithms and documentation
- Research shows that approximately 60% of nursing time in the office is spent performing triage function (formal or informal). This disruption can negatively impact clinic throughput and beneficiary flow.

Effectiveness of "Triage" – Industry Results

- 30-40% of visits to Primary Care were found to be inappropriate or could have been handled over the telephone
- When offered rapid access to medical information and advice, 77% chose not to go into the office
- 50-60% of patients choose self-care and 20-25% opt for next day appointment

Sources:

Honeycutt and Burke, Journal for Healthcare Information Management Systems Society, 1998.

Barr, Laufenberg and Sieckman, Journal for Healthcare Information Management Systems Society, 1998.

Access Management Options

OPTIONS	BENEFITS
■ Same day appointment – Appointment Clerk offers beneficiary the option to speak to nurse based on "trigger" clinical needs ■ Examples include: cold symptoms, "yeast" infection, prescription refill request	■ Increase chance of self-care because beneficiary has chosen the option ■ Increase capacity of nursing triage staff by limiting triage function to a select number of conditions ■ Provider input to select "trigger" conditions ■ Opportunity to streamline use of clinical algorithms that will increase nurse capacity and decrease length of call

Considerations to Implement Access Management Options

- Providers generate list of clinical conditions that qualify for substitute care modalities (prescription refill, cold symptoms, yeast infection). This list should be standard for all Primary Care clinics in the MTF.
- Designate number of nursing staff to accommodate needs of enrolled population, based on call volume
- Leverage existing algorithms or purchase
- As the care choice function is implemented, workflow of clinic and nursing capacity should improve due to:
  - Less interruptions to provide random “triage” with associated documentation
  - Dedicated resource(s) performing one primary duty
- Identify resource to actively manage and adjust schedule templates
- Identify clinic resource to manage same-day appointment not available, or walk-in situations

Summary of Benefits Realized- Advanced Access Model

- Reduced wait time for 3rd available appointment for CPE with assigned PCM from 25 days to 2 days
- Mayo Clinic – in Primary Care Pediatric Clinic reduced 3rd available appointment wait from 45 days to 2 days
- Sacramento, CA – improved appointment with assigned PCM from 59% to 80%
- Decrease in number of total visits range from 8% - 25%
- Improved clinical outcomes:
  - Lipids – from 59% to 88%
  - Tetanus – from 50% to 97%
  - Pneumovax – from 65% to 88%

Intersection in the Road – Which Way to Turn?

Implement Carve Out Access Model

Implement Advanced Access Model

“Tweak” Traditional Model

Assumptions Associated with Either Option

- Adequate provider and support staff resources to meet needs of the region/facility empanelled population must be available
- Leadership commitment to the change will be required
- Appointment types, lengths and guidelines will be standardized
- Provider absence from patient care will be closely managed, analyze time and reasons for non-patient care activities. Establish minimum number of providers required in clinic to maintain service levels
- Beneficiary panels will be balanced
- To drain the reservoir and work down backlog, there will be no substitute for hard work, there will be some long days
- Supply-side demand: it will not always be possible to predict demand, again some long days
- Develop robust contingency plans to accommodate vacations, deployment, mission related duties
- Develop plans to reduce demand: leverage telephone interactions with beneficiaries, define role of mid-level providers, identify clinical conditions that can be treated in group sessions

Advanced Access Implementation Steps

1) Determine start date to work down backlog and Advanced Access go-live date

2) Design process to work down backlog (all process design/redesign will use Process Flow Charts and Process Flow Work Sheet Tools)

- Length of period to work down backlog
- Number of appointments to add/day
- OT capacity for support staff/resources share/civilian
- Identify who will monitor appointments to identify opportunities to combine future appointments and/or reschedule/manage schedule template adjustments as needed

Advanced Access Implementation, continued

3) Define the “end of the day”. The time when the last beneficiary can arrive at clinic for care that day.
4) Design Medical Record Process
   - Identify process and resources to get medical record to clinic before beneficiary arrives for same day appointment
5) Design process to keep PCM updated with schedule changes that occur during the day.
   - Include frequency of update and resources
6) Develop contingency plans
   - TAD/Vacation Plan for appointments
   - Establish criteria for provider absence from patient care duties and determine minimum number of providers on duty, and assign executive agent to control templates.
   - Plans to increase supply capacity at select times (school physicals, etc)
   - When to activate TAD/Vacation schedule (>2 days)